

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08111

CERTIFICATE OF DEATH

08055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>alleg.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>Rt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>Lee</u> Middle <u>ALBRIGHT</u> Last		4. DATE OF DEATH <u>August 5</u> 19 <u>57</u> . Month <u>August</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5, 1957</u>
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>45</u>	IF UNDER 24 HRS. <u>45</u> hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md</u>
13. FATHER'S NAME <u>William George Albright</u>		14. MOTHER'S MAIDEN NAME <u>Grace Eliz. Burkett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Infant</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Wm. George Albright</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Premature birth (8 mos.)</u> 761.5 DUE TO (b) <u>Marginal Placenta Praevia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Breech Delivery (Spontaneous)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hr. 45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-5</u> , 19 <u>57</u> , to <u>8-5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-5</u> , 19 <u>57</u> , and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Diehl</u>		ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>8/5/57</u>	
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nashotles Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pocahontas, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Albright</u>		24a. REC'D BY REGISTRAR <u>8-5-57</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. P.</u>	

2061223 XV4

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

Alfred
Frost Road
Haverhill Hospital

Benjamin
Bellevue
Rt. 1

ALBRIGHT
Aug. 2, 1917

William Lloyd Albright - born 31.12.1861
Married Mary Ellen Albright
Permittee birth (8th)
Manager of Albright's
Barnet Brewery (Spartanburg)

BUREAU V. 2

AUG 12 1957

RECEIVED

11132
8-2
H.C. D. & H. M.D. 1-10-21
H.C. D. & H. 8-2

Within corporate limits

08055

CERTIFICATE OF DEATH

Reg. Dist.

08056

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>514 Fairview Ave.</u>				d. STREET ADDRESS <u>1 514 Fairview Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Appel</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt Savage, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harmon Michaels</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Edward F Appel Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>acute coronary occlusion</u> DUE TO (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs. 30 min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 29</u> , 19 <u>57</u> , to <u>Aug. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 30</u> , 19 <u>57</u> , and that death occurred at <u>3 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 S. Centre St. Cumberland, Md.</u> DATE SIGNED <u>8-30-57</u>							
ACTUAL SIGNATURE <u>C. Zimmermann</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. Zimmermann, M.D.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Luke's Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>				24a. REC'D BY REGISTRAR <u>W. Ross Cameron, Md.</u> DATE <u>Aug 31, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08056

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 63 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JESSE Middle JAMES Last ATHEY				4. DATE OF DEATH Month AUGUST 23 Day 19 Year 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen'l Farming		11. BIRTHPLACE (State or foreign country) Green Ridge Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ATHEY, ARON				14. MOTHER'S MAIDEN NAME MARGARET SHYROCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. William Iser, Oldtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pancreas with metastases 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) to biliary tract. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 16 Aug. , 19 57 , to 23 Aug. , 19 57 ; that I last saw the deceased alive on 23 Aug. , 19 57 , and that death occurred at 5:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) W Alfred Van Ormer, M.D., Cumberland, Md. DATE SIGNED 24 Aug, 57							
ACTUAL SIGNATURE W. ALFRED VAN ORMER							
PHYSICIAN'S NAME (Type) W. ALFRED VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57	22c. NAME OF CEMETERY OR CREMATORY Oldtown Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Aug. 26, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

08057

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN TB 6 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND,				d. STREET ADDRESS 307 UNION STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOMER Middle L Last BAKER				4. DATE OF DEATH Month AUGUST Day 19 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 31, 1900	
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY C & A GAS CO.	
11. BIRTHPLACE (State or foreign country) PA. Fairhope				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME BERT BAKER				14. MOTHER'S MAIDEN NAME ANNA E. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1				16. SOCIAL SECURITY NO. 214-05-9426		17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Hepatic Coma - DUE TO SLEEPING DESOPHAGEAL VARICES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of Liver DUE TO (c) 6 days 6 days 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/19/57 to 8/19/57 , that I last saw the deceased alive on 8/18/57 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above. Samuel G. Weisman ADDRESS (Street, city or town, state) 516 Washington St DATE SIGNED 8/19/57 ACTUAL SIGNATURE M.D. S.G. WEISMAN, M.D. PHYSICIAN'S NAME (Type) DR S.G. Weisman Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/21/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Aug. 20, 1957			
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 21 1957

BUREAU V. S.

DR. TOLSON

08058

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 23 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 1 215 SARATOGA STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle M. Last BARRETT				4. DATE OF DEATH Month AUGUST Day 22 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 12, 1879	
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 7 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ROBERT SCHAUECKER				14. MOTHER'S MAIDEN NAME SOPHIA Greisman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-03-9498-1		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181x Carcinoma of bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) about 1955 (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis & uremia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-28-57 to 8-22-57 that I lost saw the deceased alive on 18-16-57 and that death occurred on 11:40P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Cumberland, Md. 8-26-57							
ACTUAL SIGNATURE DR. H. TOLSON							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR Aug 26, 1957	
				24b. REGISTRAR'S SIGNATURE A. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

Reg. Dist. No.

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

STREET ADDRESS

CITY AND STATE

SEX

AGE

DATE

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

NAME OF HOSPITAL OR OTHER INSTITUTION

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

BUREAU V. 3

AUG 27 1951

RECEIVED

08059

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 WESTERNPORT			
f. STREET ADDRESS M 125 CHURCH ST.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle MARTIN Last BERRY, SR.		4. DATE OF DEATH Month AUGUST 30, Day 1957		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 19, 1913		9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE-SELF EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BARTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HARRY BERRY			
14. MOTHER'S MAIDEN NAME ELLA BROOKS				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction, posterior-lateral, acute, extensive DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic vascular disease? DUE TO Diabetes mellitus (c) 16 years.				INTERVAL BETWEEN ONSET AND DEATH 12 hours.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 21 aug. 1957 to 30 aug. 1957 , that I last saw the deceased alive on 30 aug. 57 , 19____, and that death occurred at 1:32 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Center St. Cumberland, Md. DATE SIGNED 30 aug. 57							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				PHYSICIAN'S NAME (Type) W. ALFRED VAN ORMER, Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal, Westernport, Maryland.				24a. REC'D BY REGISTRAR Sept. 2, 1957			
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE May 19, 1922		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION Attorney		8. MARITAL STATUS Single		9. EDUCATION High School	
10. PLACE OF DEATH Baltimore, Maryland		11. DATE OF DEATH June 4, 1968		12. TIME OF DEATH 10:00 AM	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. MEDICAL HISTORY None	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESSES J. Edgar Hoover	
19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover		21. SIGNATURE OF BURIAL OFFICIAL J. Edgar Hoover	

BUREAU A. E.

SEP 4 1967

RECEIVED

08060

CERTIFICATE OF DEATH

08061

Reg. Dist. No.

Within corporate limits.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. STREET ADDRESS 80 Auburn Ave.			
3. NAME OF DECEASED (Type or print) Trevnor J. BABY BOY BROWN				4. DATE OF DEATH Month AUGUST 22, Day 19 Year 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 19, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. BROWN				14. MOTHER'S MAIDEN NAME DOROTHY M. MARKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Brown		Address 80 Auburn Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis Congenital 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James B. Whitworth M.D.							
PHYSICIAN'S NAME (Type) F.B. WHITWORTH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-57		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug. 23, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

2060273XV5

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. SMITH		2. SEX MALE		3. AGE 35 YEARS		4. RACE WHITE		5. DATE OF DEATH AUGUST 25, 1957		6. PLACE OF DEATH BALTIMORE, MARYLAND	
7. OCCUPATION LABORER		8. MARITAL STATUS MARRIED		9. PLACE OF BIRTH BALTIMORE, MARYLAND		10. DATE OF BIRTH MAY 10, 1922		11. NAME OF MOTHER MARY E. SMITH		12. NAME OF FATHER JOHN E. SMITH	
13. CAUSE OF DEATH HEART DISEASE		14. MANNER OF DEATH NATURAL		15. PLACE OF INTERMENT BALTIMORE, MARYLAND		16. DATE OF INTERMENT AUGUST 27, 1957		17. NAME OF INTERMENT PLACE BALTIMORE, MARYLAND		18. SIGNATURE OF DECEASED JAMES E. SMITH	
19. SIGNATURE OF PHYSICIAN JAMES E. SMITH		20. SIGNATURE OF MINISTER JAMES E. SMITH		21. SIGNATURE OF CORONER JAMES E. SMITH		22. SIGNATURE OF DECEASED JAMES E. SMITH		23. SIGNATURE OF DECEASED JAMES E. SMITH		24. SIGNATURE OF DECEASED JAMES E. SMITH	

BUREAU V. S.

AUG 26 1957

RECEIVED

Within corporate limits

08061

CERTIFICATE OF DEATH

08062

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MIDDLE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 400 SPRINGDALE STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HOMA Middle MARGARET Last COMBS				4. DATE OF DEATH Month AUGUST Day 28 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 20 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) DAVIS, WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY MALE				14. MOTHER'S MAIDEN NAME SARAH MALE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital, Cumberland, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs (c) 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/2/52 19, to 8/28/57 19, that I last saw the deceased alive on 8/28/57 19, and that death occurred at 2:35 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 8/29/57							
ACTUAL SIGNATURE RICHARD J. WILLIAMS							
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/57		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug. 30, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08123

CERTIFICATE OF DEATH

Reg. Dist. No.

08063

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland			c. LENGTH OF STAY IN 1b 20 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 5, Winchester Road			e. STREET ADDRESS Route 5, Winchester Rd		
3. NAME OF DECEASED (Type or print) IRA First ERNEST Middle COSNER Last			4. DATE OF DEATH Aug. 26, Month Aug. Day 26, Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1889		9. AGE (In years lost birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulding Dept		10b. KIND OF BUSINESS OR INDUSTRY Auto Tires		11. BIRTHPLACE (State or foreign country) Scheer, W.Va.	
13. FATHER'S NAME Soloman F. Cosner			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Betty Kuhn			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 232 09 4190			17. INFORMANT Address Delzia Cosner, Rt. 5, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June , 19 52 , to August , 19 57 , that I last saw the deceased alive on June , 19 57 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. 456 N. Centre St.		DATE SIGNED 8/27/57	
PHYSICIAN'S NAME (Type) LEO H. LEY JR. Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/29/1957	22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR Aug. 28, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased William H. Knight, Cumberland, Me.		Age 82 years		Sex Male		Race White		Date of Birth Mar. 19, 1887		Date of Death Aug. 20, 1957	
Place of Birth Cumberland, Me.		Usual Residence Cumberland, Me.		Cause of Death Heart Disease		Manner of Death Natural		Occupation Retired		Signature of Physician Betsy Kohn	
Signature of Registrar Betsy Kohn		Signature of Coroner Betsy Kohn		Signature of Medical Examiner Betsy Kohn		Signature of Health Officer Betsy Kohn		Signature of Funeral Director Betsy Kohn		Signature of Burial Director Betsy Kohn	
Burial Place Cumberland, Me.		Burial Date Aug. 20, 1957		Burial Time 10:00 A.M.		Burial Place Cumberland, Me.		Burial Date Aug. 20, 1957		Burial Time 10:00 A.M.	

RECEIVED
JUG 29 1957
BUREAU V. 5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08064

Reg. Dist. No.

08124

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Paw Paw, W. Va.		c. LENGTH OF STAY IN 1b 11 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Paw Paw, W. Va. X0		d. STREET ADDRESS Route I Paw Paw, W. Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route I, Paw Paw, W. Va.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Connie Middle Jean Last Crabtree		4. DATE OF DEATH Month August Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1946
9. AGE (In years last birthday) 11 yrs.		IF UNDER 1 YEAR Months 22 Days 22	IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter D. Crabtree		14. MOTHER'S MAIDEN NAME Josephine Alkire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Walter D. Crabtree, RtI Paw Paw, W. V		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Skull Fracture (c) 812X DUE TO (a) Fracture of right Femur PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right Femur		INTERVAL BETWEEN ONSET AND DEATH 5 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by a truck	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Aug. 27, 1957 p. m. 3:00 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Paw Paw, (County) Allegany, (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED Aug. 27, 1957	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aoting	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/30/57	22c. NAME OF CEMETERY OR CREMATORY Sulphur Spgs. Meth. Church RD Paw Paw, W. Va.	
22d. LOCATION (City, town, or county) (State) Berkoley Spgs. W. Va.		22e. REC'D BY REGISTRAR Sept. 3, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE PARKS FUN. HOME		24b. REGISTRAR'S SIGNATURE Mrs. Jay Duckworth	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
SEP 5 1957
BUREAU V. S.

08062

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Unionland</u>		<u>9 DAYS</u>		TOWN <u>MT. SAVAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>LUCINDA M. CUNNINGHAM</u>				4. DATE OF DEATH <u>Aug. 23 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT. 9-22 65</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		9. AGE last birthday <u>65</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOSEPH CROWE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA KIRBY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Charles Cunningham Int. Savage Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>dissecting aortic aneurysm</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>diabetes</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-23</u> , 19 <u>57</u> , to <u>8-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-23</u> , 19 <u>57</u> , and that death occurred at <u>9:57</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>57 Green St. Unionland Md.</u> DATE SIGNED <u>8-24-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-26-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick</u>		LOCATION (City, town, or county) (State) <u>Int. Savage Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M-

11005

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

CERTIFICATE OF DEATH

18003

Reg. Dist. No.

A. DECEASED PERSON'S NAME - LAST, FIRST, MIDDLE

DATE OF DEATH

DATE OF BIRTH

SEX
AGE
OCCUPATION
EDUCATION
MARRIAGE

PLACE OF BIRTH
PLACE OF DEATH
PLACE OF INTERMENT

1. CAUSE OF DEATH
2. MANNER OF DEATH
3. MEDICAL HISTORY
4. PRESENT ILLNESS
5. PREVIOUS ILLNESSES
6. SURGICAL HISTORY
7. MEDICATION
8. ALLERGIC REACTIONS
9. SOCIAL HISTORY
10. FAMILY HISTORY
11. PERSONAL HISTORY
12. PHYSICAL EXAMINATION
13. LABORATORY TESTS
14. X-RAY EXAMINATION
15. OTHER TESTS
16. PATHOLOGICAL FINDINGS
17. CLINICAL COURSE
18. TREATMENT
19. PROGNOSIS
20. COMMENTS

16. MEDICAL HISTORY

DATE OF DEATH

PLACE OF BIRTH
PLACE OF DEATH
PLACE OF INTERMENT

17. CLINICAL COURSE

18. TREATMENT
19. PROGNOSIS
20. COMMENTS

BUREAU V. 2

AUG 27 1957

RECEIVED

ENCLOSURE

1. This certificate is required for all deaths occurring in the State of Mississippi, whether the death is natural, accidental, or suicidal. It must be completed by the attending physician or the medical examiner, and filed with the local health department within 48 hours of the death. The certificate is a legal document and must be kept for a period of 10 years. The information on this certificate is used for the purpose of determining the cause of death and for the purpose of compiling statistics on the health of the State. The certificate is also used for the purpose of determining the eligibility of the deceased for certain benefits. The certificate is a legal document and must be kept for a period of 10 years. The information on this certificate is used for the purpose of determining the cause of death and for the purpose of compiling statistics on the health of the State. The certificate is also used for the purpose of determining the eligibility of the deceased for certain benefits.

08112

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> X0	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>R.D.#1, Box 133, Klondike</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Cutter</u> Last <u>Cutter</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-57</u>
9. AGE (In years last birthday) <u>05</u> yrs.		IF UNDER 1 YEAR Months <u>05</u> Days <u>05</u> Hours <u>05</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William W. Cutter</u>		14. MOTHER'S MAIDEN NAME <u>Helen Marie Crowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. W. Cutter, R.D.#1, Box 133, Frostburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANENCEPHALY</u> <u>750x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PHARYNGEAL</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Minutes</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 19</u> , 19 <u>57</u> , to <u>August 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 19</u> , 19 <u>57</u> , and that death occurred at <u>2:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>134 E Main Frostburg, Md.</u> DATE SIGNED <u>8/20/57</u>			
ACTUAL SIGNATURE <u>John C. Deucas</u> M.D.		DATE SIGNED <u>8/20/57</u>	
PHYSICIAN'S NAME (Type) <u>John C. Deucas</u>		ADDRESS <u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cutter Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Klondike Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial Home</u>		24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg</u>	
24b. REGISTRAR'S SIGNATURE <u>2061141XVI</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>September 3, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>Dr. J. K. Smith</i>		18. SIGNATURE OF REGISTRAR <i>Dr. J. K. Smith</i>	

BUREAU V. B.

SEP 3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

080672

Reg. Dist. No.

08113

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westernport</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>River Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna L. Dellinger</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 1 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 29, 1879</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Oliver H. Bruce</u>				14. MOTHER'S MAIDEN NAME <u>Martha North</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Norris Bruce, Westernport, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
331x IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/25 1957</u> to <u>8/1 1957</u>, that I last saw the deceased alive on <u>8/1 1957</u>, and that death occurred at <u>8/1 1957</u> M, from the causes and on the date stated above.							
SIGNATURE <u>P. E. Berry</u>		M.D. <u>Predmont W. Va.</u>		ADDRESS (Street, city, town, state) <u>Allegany Westernport, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 4, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town or county) (State) <u>Allegany Westernport, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>AUG 5 1957</u>		REGISTRAR'S SIGNATURE <u>Joan C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold F. Fulkerson</u>		ADDRESS <u>Predmont W. Va.</u>	

CERTIFICATE OF DEATH

Date of Birth

Usual Residence (House or Apartment)

Age at Death

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Date of Death

Time of Death

Sex

Age at Death

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

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Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

Usual Residence (House or Apartment)

BUREAU V. S.

AUG 5 1933

RECEIVED

08068

08063

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>11 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>532 Greene St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Johnson Meade Denson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 2, 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam Denson (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Mariria Johnson (Deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Pt. s chart</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>uremia</u>						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cardio-vascular-renal disease</u>						2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis</u>						4 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-3-</u> 19 <u>55</u> , to <u>5-28-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5-28-</u> 19 <u>57</u> , and that death occurred at <u>10:15 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. Prings</u>				ADDRESS <u>57 Greene St. Cumberland Md</u>		DATE SIGNED <u>5-30-57</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 30/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>Aug 31/1957</u>		REGISTRAR'S SIGNATURE <u>W. H. Cameron M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cum. Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO. 12

NAME OF DECEASED (PRINTED OR WRITTEN)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

ICD-9 CODE

ICD-9 CODE

ICD-9 CODE

ICD-9 CODE

ICD-9 CODE

ICD-9 CODE

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BUREAU V. A.

SEP 4 1957

RECEIVED

08064

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08064

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 515 Linden St.		d. STREET ADDRESS /515 Linden St.	
3. NAME OF DECEASED (Type or print) First carl Middle William Last Dickerhoof		4. DATE OF DEATH Month Aug. Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1883
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Worker		10b. KIND OF BUSINESS OR INDUSTRY Glass	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph L. Dickerhoof		14. MOTHER'S MAIDEN NAME Catherine H. Rank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 213 16 9605	
17. INFORMANT Hazel Wilkinson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular disease (a), stating the underlying cause last. DUE TO (c) ***			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 4:20 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarellic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/1957	22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Aug. 26, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JUN 27 1957
BUREAU V. S.

JUN 27 1957
BUREAU V. S.

08065 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland , b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 1/23/53		d. STREET ADDRESS 506 Baltimore Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle B. Last Field		4. DATE OF DEATH Month August Day 22 , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Moreland		14. MOTHER'S MAIDEN NAME Rachael Seaton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/23/57 , 19____, to 8/22/57 , 19____, that I last saw the deceased alive on 8/22/57 , 19____, and that death occurred at 2:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 8/22/57			
ACTUAL SIGNATURE James E. McLean		M.D. 49 Greene St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/24/1957	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery Levels	22d. LOCATION (City, town, or county) (State) W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right, Cumberland, Md.		24. REC'D BY REGISTRAR Aug 23, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED David McFarland		MARRIAGE None	
DATE OF BIRTH 1923		PLACE OF BIRTH Maryland	
DATE OF DEATH Aug 26 1957		PLACE OF DEATH Maryland	
TIME OF DEATH 10:21 AM		CAUSE OF DEATH Cerebral Hemorrhage	
SEX Male		RACE White	
AGE 34		OCCUPATION None	
EDUCATION High School		RELIGION None	
MANNER OF DEATH Natural		PLACE OF INTERMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	

BUREAU V. 2

AUG 26 1957

RECEIVED

1957
JAMES E. McFarland
1957
JAMES E. McFarland
1957
JAMES E. McFarland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08071

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		c. LENGTH OF STAY IN 1b 48 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Luke			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 310 Pratt St				d. STREET ADDRESS 310 Pratt St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edwin Middle Clay Last Fisher				4. DATE OF DEATH Month Aug Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1886		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Millard Fisher				14. MOTHER'S MAIDEN NAME Lulu Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-9423A		17. INFORMANT Address Mrs. E.C. Fisher-Luke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio-vascular disease (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/13/57	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/15/57	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 8-15-57	24b. REGISTRAR'S SIGNATURE John C. Kelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUG 19 1957

RECEIVED

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

08066

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		LENGTH OF STAY (In this place) <u>19 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAVAGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>BOX 193</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PETER</u>		(Middle) <u>FLEEGLE</u>		(Last)		(Month) (Day) (Year) <u>8-5-57</u> <u>19</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct. 20, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired) <u>Bottling House Employee - Brewing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. FLEEGLE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH CATHERINE FLEEGLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>PATIENTS CHART</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Infarctions</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular Disease</u>				<u>9 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Complete heart failure</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1947</u> , to <u>8/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Deville G. Weisman</u>				ADDRESS (Street, city, town, state) <u>59 Green St. Cumberland 1</u>			
DATE <u>8/7/57</u>				DATE SIGNED <u>8/7/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 7, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md</u>	
24. REC'D BY REGISTRAR <u>Aug 7, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>		ADDRESS <u>Cumberland, Md</u>	

[illegible]

BUREAU V. S.

AUG 10 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08067 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08073

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>643 Washington St.,</u>			d. STREET ADDRESS <u>643 Washington St.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Montfort Fowler</u>			4. DATE OF DEATH Month Day Year <u>August 22, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Fishkill Plains, N. Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Jeremiah D. Fowler</u>			14. MOTHER'S MAIDEN NAME <u>Eliza Montfort</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No,</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss. Lida Fowler Hopewell Jct. New York</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Ostial Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Ostial Sclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>30 Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Acting.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hopewell Jct. N. Y.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>			ADDRESS <u>Cumberland, Md.</u>		
24a. REC'D BY REGISTRAR <u>Aug. 26, 1957</u>			24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>		

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2

AUG 27 1957

RECEIVED

08114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 9 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03X0.2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1229 Vogt Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY				4. DATE OF DEATH Month Aug. Day 26 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. 9 Min. 35	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Barbara Garsuch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Garsuch, 1229 Vogt Ave., Balto.		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature Birth DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 hrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 26, 1957 , to AUG. 26, 1957 , that I last saw the deceased alive on AUG. 26, 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED							
ACTUAL SIGNATURE Martin Rothstein, M.D.				PHYSICIAN'S NAME (Type) Martin Rothstein, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-27-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 8-27-57		24b. REGISTRAR'S SIGNATURE Nancy H. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3
SEP

RECEIVED
SEP 3 1957

08068

CERTIFICATE OF DEATH

08075

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG			
f. STREET ADDRESS 54 BEALL ST.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last GRAHAME				4. DATE OF DEATH Month AUGUST Day 19 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 8, 1902	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		11. BIRTHPLACE (State or foreign country) Elks Lodge, Frostburg-MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J.C. GRAHAME				14. MOTHER'S MAIDEN NAME CECELIA MALLOY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 290-10-3371		17. INFORMANT MEMORIAL HOSPITAL Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 DUE TO General Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subtotal Gastric Cancer (c) Frequent Burro Shoggy							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 11, 1957 to Aug 19, 1957 that I last saw the deceased alive on Aug 18, 1957 and that death occurred at 7:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. E. ENFIELD				DATE SIGNED Aug 21, 1957			
PHYSICIAN'S NAME (Type) S. E. ENFIELD				M.D. Cumberland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Cemetery Frostburg, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.				24. REC'D BY REGISTRAR Aug. 21, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

08069

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CUMBERLAND</u>		<u>8 months</u>		TOWN <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>SACRED HEART HOSPITAL</u>				<u>248 COLUMBIA ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARGARET</u> (Middle) <u>W.</u> (Last) <u>GREENWALD</u>				(Month) <u>8-11</u> (Day) <u>57</u> (Year) <u>19</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>1-19-1882</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housekeeper at Home</u>					<u>Maryland</u>		<u>USA</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Will Weigand</u>				<u>ISABELLE XXXXXX Friese</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>HUSBAND</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A)				<u>Coronary infarction</u>		<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 14, 1957</u> to <u>Aug 14, 1957</u> , that I last saw the deceased alive on <u>Aug 14, 1957</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Iwazicki, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u>		DATE SIGNED <u>8/16/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/17/57</u>		<u>St. Lukes Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 17, 1957</u>		<u>Dr. Ross Cameron, M.D.</u>		<u>H. Lee Silcox</u>		<u>Cumberland, Md.</u>	
<u>Silcox</u>		<u>Acting Registrar</u>					

INSTRUCTIONS

1. **WITHIN CORPORATE LIMITS**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

5281-1-1

BUREAU V. 5

AUG 20 1957

RECEIVED

J. Edgar Hoover

455

211

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08077

Reg. Dist. No.

08070

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 7 Hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 020 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 471 Fort Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) JAMES SCOTT HAMMOND		4. DATE OF DEATH Month August Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY McLaughlin Farm	11. BIRTHPLACE (State or foreign country) McNeil, West Virginia	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Homer Hammond	14. MOTHER'S MAIDEN NAME Tina Cook
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW1	16. SOCIAL SECURITY NO. 213-12-9342	17. INFORMANT Mrs. Mary S. Hammond	Address 471 Fort Avenue Cumberland, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs not known
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 8/11/57
EXAMINER'S NAME (Type) Benedict Skitarelic	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	24a. REC'D BY REGISTRAR Aug. 12, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

08115

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN 1b 85 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Philos Ave				e. STREET ADDRESS 318 Philos Ave.			
3. NAME OF DECEASED (Type or print) Onma Alonzo Harrison				4. DATE OF DEATH Aug 16 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1872		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Lumber mill Construction		11. BIRTHPLACE (State or foreign country) Westernport, Md.	
13. FATHER'S NAME Thomas Harrison				14. MOTHER'S MAIDEN NAME Mary O'Haver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-16-5936			
17. INFORMANT Mrs. Nannie N. Simmons-Westernport, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 Years 5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug. 14, 1957 , to Aug 16, 1957 , that I last saw the deceased alive on Aug. 15, 1957 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED Aug 17, 1957							
ACTUAL SIGNATURE Paul H. Wilson M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 8-19-57	
				24b. REGISTRAR'S SIGNATURE John C. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 21 AUG

RECEIVED

BUREAU V. S.

CERTIFICATE OF DEATH

08071

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>		<u>8 days</u>		TOWN <u>Cumberland,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>35 Race St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Azariah</u> (Middle) <u>Humbertson</u> (Last)				(Month) <u>Aug.</u> (Day) <u>2</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>August 24, 1888</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Conductor</u>		<u>Railroad</u>		<u>Maryland Ocean</u>		<u>USA U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Howard Humbertson</u>				<u>Amanda Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-09-5647</u>		<u>Patient's Chart.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>						<u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>coronary artery block</u>						<u>6 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>8-31-57</u>		<u>basal skull amputation of left leg</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-24</u> , 19 <u>57</u> , to <u>8-2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-1</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Leans Brown</u>				ADDRESS (Street, city, town, state) <u>57 Green St., Cumberland Md</u>		DATE SIGNED <u>8-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>8-5-57</u>		<u>Hyndman Cem</u>		<u>Hyndman, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 5, 1957</u>		<u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>		<u>James F. Scarpelli</u>		<u>Cumberland,</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

Aug 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08080

08126

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Detmold Street		d. STREET ADDRESS 1 Detmold Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George F.S. Jeffrey		4. DATE OF DEATH Month Day Year August 8 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 16, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant	
11. BIRTHPLACE (State or foreign country) Ballieston, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Jeffrey		14. MOTHER'S MAIDEN NAME Elizabeth Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-6388	
17. INFORMANT Mrs. George Jeffrey		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arterial Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) "Wife" DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 7 , 19 57 , to Aug 8 , 19 57 , that I last saw the deceased alive on Aug 7 , 19 57 , and that death occurred at 130A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul B. Wilson		M.D. Piedmont, W. Va.	
PHYSICIAN'S NAME (Type) Paul B. Wilson		DATE SIGNED 8-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/57	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. RECEIVED BY REGISTRAR 8/11/57		24b. REGISTRAR'S SIGNATURE Janette M. Goal	

ARKYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

AUG 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08081

Reg. Dist. No. 8

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03x22	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Water Station Run		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Jeffrey Last Jeffrey		4. DATE OF DEATH Month Aug. Day 12th. Year 1957 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Salesman	11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel Jeffrey		14. MOTHER'S MAIDEN NAME Elizabeth Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-7544	
17. INFORMANT Mrs. Julius Wattenschaidt, Sister		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> acting	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug, 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN?		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR 8/14/57		24b. REGISTRAR'S SIGNATURE Janette M Boal	

BUREAU V. 3

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08072
CERTIFICATE OF DEATH

08082

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HR.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle LESLIE Last JENKINS				4. DATE OF DEATH Month AUGUST Day 7 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1953	
9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 7 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JONATHAN JENKINS				14. MOTHER'S MAIDEN NAME MARY HOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital, Cumberland, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Acute Circulatory Failure DUE TO (b) Acute Virus Laryngitis DUE TO (c) Acute Viral Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 5 min. 7 hrs. 10 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from 8-7-57 to Aug 7, 1957 that I lost saw the deceased alive on Aug 7, 1957 and that death occurred at 11:05 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 7th St. Cumberland MD DATE SIGNED Harold W. Eliason							
ACTUAL SIGNATURE Harold W. Eliason				M.D. 126 7th St. Cumberland MD			
PHYSICIAN'S NAME (Type) Harold W. Eliason, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Sedalia Cemetery		22d. LOCATION (City, town, or county) (State) Sedalia, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland.				24a. REC'D BY REGISTRAR Aug 8, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES H. HARRIS		MALE		35	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
AUG 8 1937		HOSPITAL		HEART DISEASE	
RESIDENCE		OCCUPATION		EDUCATION	
BALTIMORE, MD.		LABORER		HIGH SCHOOL	
MARRIED		SINGLE		WIDOW	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF DEATH	
JAN 15 1902		BALTIMORE, MD.		HEART DISEASE	
MARRIED		SINGLE		WIDOW	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CAUSE OF DEATH	
JAN 15 1902		BALTIMORE, MD.		HEART DISEASE	
MARRIED		SINGLE		WIDOW	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
AUG 8 1937		HOSPITAL		HEART DISEASE	
RESIDENCE		OCCUPATION		EDUCATION	
BALTIMORE, MD.		LABORER		HIGH SCHOOL	
MARRIED		SINGLE		WIDOW	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF DEATH	
JAN 15 1902		BALTIMORE, MD.		HEART DISEASE	
MARRIED		SINGLE		WIDOW	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CAUSE OF DEATH	
JAN 15 1902		BALTIMORE, MD.		HEART DISEASE	
MARRIED		SINGLE		WIDOW	

BUREAU V. S.

AUG 9 1937

RECEIVED

RECEIVED

08116

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 111 Park Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELSIE Middle JOHNSON Last JOHNSON				4. DATE OF DEATH Month Aug. Day 16, Year 19 57			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-16-1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lashan Washington				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Guy Johnson, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 mo ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9, 1957 to Aug 15, 1957 that I last saw the deceased alive on Aug 15, 1957 and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. O. McLane M.D.				ADDRESS (Street, city or town, state) Frostburg Aug 16 1957			
PHYSICIAN'S NAME (Type) W. O. McLane M.D.				DATE SIGNED MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 8-18-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 23 1957

RECEIVED

08073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 Humbird Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JACOB</u> <u>ERNEST</u> <u>KELLER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <u>DIVORCED</u>	8. DATE OF BIRTH <u>March 20, 1882</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Edinburgh, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs. Robert Hobell, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-1</u> <u>Coronary Thrombosis - Occlusion - Acute</u> DUE TO (b) <u>Coronary Artery Disease - Chronic</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cumberland</u>				20g. (County) <u>Maryland</u>		20h. (State) <u>Maryland</u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>57</u> , and that death occurred at <u>7:45 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Iverson Himmelwright</u>				ADDRESS (Street, city or town, state) <u>133 Virginia Ave, Cumberland, Md</u>			
PHYSICIAN'S NAME (Type) <u>G. Iverson Himmelwright</u>				DATE SIGNED <u>8/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>DATE 8-26-1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 27 106

RECEIVED

Within 10 days

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08085

08074

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 56 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS 11 Race Street	
3. NAME OF DECEASED (Type or print) John Thomas King		4. DATE OF DEATH August 28 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1880
9. AGE (In years and birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) 21 Bridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick King		14. MOTHER'S MAIDEN NAME Margaret Tierney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm. Paul Yarnall, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-57	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24. REC'D BY REGISTRAR Aug. 29, 1957	
25. REGISTER'S SIGNATURE W. Ross Cameron, M.D.		26. REGISTER'S SIGNATURE Acting Registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
DEPARTMENT OF HEALTH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
RACE: [illegible]
COLOR: [illegible]
SEX: [illegible]
AGE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

BUREAU V. S.

AUG 30 1957

RECEIVED

DR. HODGES & MOULD

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARTHUR 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last KISAMORE		4. DATE OF DEATH Month AUGUST Day 25 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 AUGUST 25, 1957
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ASA KISAMORE		14. MOTHER'S MAIDEN NAME CLODA BELL WHETZEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 Defective membrane DUE TO prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) abruptio placentae DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/25/57 to 8/26/57 that I last saw the deceased alive on 8/26/57 , and that death occurred at 1:10 A.M. from the causes and on the date stated above. W.R. Hodges Cumberland, Md. ACTUAL SIGNATURE M.D. DATE SIGNED			
PHYSICIAN'S NAME (Type) W. Royce Hodges, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)
Burial	Aug 26, 1957	St. Mary's Cemetery	St. Mary's, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaffer, Petersburg, W. Va.		24a. REC'D BY REGISTRAR Aug 26, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED WEST V. BOWEN		AGE 3 DAYS		SEX MALE		RACE WHITE		EDUCATION NONE		OCCUPATION NONE		MARRIAGE NONE		RELIGION NONE		BIRTHPLACE NONE		DATE OF BIRTH NONE		PLACE OF BIRTH NONE		DATE OF DEATH NONE		PLACE OF DEATH NONE		CAUSE OF DEATH NONE		MANNER OF DEATH NONE		SIGNATURE NONE		DATE NONE		PLACE NONE	
FATHER'S NAME NONE		MOTHER'S NAME NONE		FATHER'S OCCUPATION NONE		MOTHER'S OCCUPATION NONE		FATHER'S BIRTHPLACE NONE		MOTHER'S BIRTHPLACE NONE		FATHER'S DATE OF BIRTH NONE		MOTHER'S DATE OF BIRTH NONE		FATHER'S PLACE OF BIRTH NONE		MOTHER'S PLACE OF BIRTH NONE		FATHER'S CAUSE OF DEATH NONE		MOTHER'S CAUSE OF DEATH NONE		FATHER'S MANNER OF DEATH NONE		MOTHER'S MANNER OF DEATH NONE		FATHER'S SIGNATURE NONE		MOTHER'S SIGNATURE NONE		DATE NONE		PLACE NONE	
FATHER'S EDUCATION NONE		MOTHER'S EDUCATION NONE		FATHER'S OCCUPATION NONE		MOTHER'S OCCUPATION NONE		FATHER'S BIRTHPLACE NONE		MOTHER'S BIRTHPLACE NONE		FATHER'S DATE OF BIRTH NONE		MOTHER'S DATE OF BIRTH NONE		FATHER'S PLACE OF BIRTH NONE		MOTHER'S PLACE OF BIRTH NONE		FATHER'S CAUSE OF DEATH NONE		MOTHER'S CAUSE OF DEATH NONE		FATHER'S MANNER OF DEATH NONE		MOTHER'S MANNER OF DEATH NONE		FATHER'S SIGNATURE NONE		MOTHER'S SIGNATURE NONE		DATE NONE		PLACE NONE	
FATHER'S EDUCATION NONE		MOTHER'S EDUCATION NONE		FATHER'S OCCUPATION NONE		MOTHER'S OCCUPATION NONE		FATHER'S BIRTHPLACE NONE		MOTHER'S BIRTHPLACE NONE		FATHER'S DATE OF BIRTH NONE		MOTHER'S DATE OF BIRTH NONE		FATHER'S PLACE OF BIRTH NONE		MOTHER'S PLACE OF BIRTH NONE		FATHER'S CAUSE OF DEATH NONE		MOTHER'S CAUSE OF DEATH NONE		FATHER'S MANNER OF DEATH NONE		MOTHER'S MANNER OF DEATH NONE		FATHER'S SIGNATURE NONE		MOTHER'S SIGNATURE NONE		DATE NONE		PLACE NONE	

BUREAU V. 8

JUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08087

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN Tb <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>210 W. First Street</u>				d. STREET ADDRESS <u>210 W. First Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles H Kurtz</u>				4. DATE OF DEATH Month Day Year <u>8 14 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-1883</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Adison, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Amos Kurtz</u>				14. MOTHER'S MAIDEN NAME <u>Anna Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-09-8104</u>		17. INFORMANT Address <u>Roy Kurtz, LaVale, Md. Son</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Erosion of Anthracotic Lymph node in bronchus</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 Min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul D. Matthaei, Frostburg, Md.</u>				ADDRESS <u>210 W. First Street</u>		24a. REC'D BY REGISTRAR <u>8-18-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Rose</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form No. 10

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1910	
Place of Birth		Cause of Death		Manner of Death		Occupation	
Boston, Mass.		Heart Disease		Natural		Teacher	
Date of Death		Time of Death		Place of Death		Physician	
Aug 20, 1957		10:30 AM		Home		Dr. Smith	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 5.

AUG 23 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08088

08076

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3.½ hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Barton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 7 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Meek Last Kyle				4. DATE OF DEATH Month Aug. Day 5 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29-1897		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 60 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant - Allegany Co. Sylvan Retreat.		10b. KIND OF BUSINESS OR INDUSTRY Retreat.		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Kyle				14. MOTHER'S MAIDEN NAME A nna Meek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-10-4426		17. INFORMANT Address (wife) Laura Kyle, Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 541.0 IMMEDIATE CAUSE (a) Exsanguination DUE TO (b) Hemorrhage from peptic ulcer. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aug. 5-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or county) (State) Barton, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.				24a. REC'D BY REGISTRAR Aug. 6, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

RECEIVED
AUG 7 1957
BUREAU V. 2

08118

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 3 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle H. Last Lewis				4. DATE OF DEATH Month August Day 1st , 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13th, 1909	
9. AGE (In years lost, birthday) 47 yrs.		IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min.		IF UNDER 24 HRS. Months 47 Days 47 Hours 47 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Textiles				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Benjamin B. Lewis				14. MOTHER'S MAIDEN NAME Katherine Orndoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or years of service) WW 2				16. SOCIAL SECURITY NO. 217-10-5526			
17. INFORMANT Mrs. Marie Y. Lewis,				Address 30 Park Ave., Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis (Lymphoma) 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH 2 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 7, 1955 , to Aug. 1, 1957 , that I last saw the deceased alive on Aug. 1, 1957 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED 8/2/57			
ACTUAL SIGNATURE Martin Rothstein, M.D.							
PHYSICIAN'S NAME (Type) Dr. Martin Rothstein				48 Broadway, Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-3-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 8-3-57			
24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. R...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

7 1957

RECEIVED

1
Within corporate limits

08077

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS R.D. 3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First David Middle Clinton Last Lough				4. DATE OF DEATH Month August Day 18 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Mar. 29, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Lough				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Walter Walter Lough-Westernport, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting				DATE SIGNED August 18, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Aug. 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Maysville Cem		22d. LOCATION (City, town, or county) (State) Maysville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR Aug. 22, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.				Acting Registrar			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUG 23 1957

RECEIVED

08078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. - If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 500 Kingsley St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Hazel</u> Last <u>Luteman</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19-1902</u>	
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - Waitress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. of F.W.</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Dean</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>219-14-7066</u>			
17. INFORMANT <u>(son) Joseph R. Luteman, Cumberland, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>Uremia due to</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic glomerulonephritis</u>							
DUE TO <u>Cerebral arteriosclerosis (marked) also had- 3 yrs.</u>							
Conditions, if any, which gave rise to immediate cause (b) <u>Fractured 6, 7, 8, 9th ribs left side, fractured</u>							
DUE TO <u>left wrist and head injury, 1 month & 3 days.</u>							
causing the underlying auto accident 7-6-1957							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Auto accident not a contributing cause of death.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>a small cigar.</u>			
20c. TIME OF INJURY Month, Day, Year <u>2 Hour 8 m. July 6 19 57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway, circle at Fairgo</u>				20f. (City or town) <u>R. 7A. #5 Allegany</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>Aug. 12, 1957</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Pauls Cem</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Right, Cumberland, Md</u>				24a. REC'D BY REGISTRAR <u>Aug. 10, 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>W. Ross Capron, M.D.</u>				24c. CHIEF MEDICAL EXAMINER <u>H. V. Deming M.D.</u>			
24d. ASSISTANT MEDICAL EXAMINER				24e. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug. 9-1957</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

Aug 13 1957

RECEIVED

Within corporate limits

08073

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 73 DAYS			
d. NAME OF HOSPITAL (If in hospital, give full address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DENNIS Middle MANKAMYER Last MANKAMYER				4. DATE OF DEATH Month AUGUST Day 6 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern & Restaurant- Owner				10b. KIND OF BUSINESS OR INDUSTRY PENNA. Rockwood, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADOLPH MANKAMYER				14. MOTHER'S MAIDEN NAME LOUISE HINNIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-I4-6846		17. INFORMANT Address John H. Mankamyier Sutton Nebr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 25, 1957 to Aug. 6, 1957 that I last saw the deceased alive on Aug. 6, 1957 and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland Md. DATE SIGNED 8/7/57							
ACTUAL SIGNATURE Clay E. Durrett				PHYSICIAN'S NAME (Type) CLAY E. DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-57		22c. NAME OF CEMETERY OR CREMATORY Grandview Cem.		22d. LOCATION (City, town, or county) (State) Johnstown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.				24a. REC'D BY REGISTRAR Aug. 7, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08080

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>224 Baltimore Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Eda</u> Middle <u>C.</u> Last <u>Mathews</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Conrad Zimmerman</u>			14. MOTHER'S MAIDEN NAME <u>Mary Gruber</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Bancroft Hetzel</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Left Breast</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>8 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-15-57</u> 19____, to <u>8-16-57</u> , 19____, that I last saw the deceased alive on <u>8-16-57</u> , 19____, and that death occurred at <u>8:20 P.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. C. Zimmerman</u> M.D.			ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>8/17/57</u>		
PHYSICIAN'S NAME (Type) <u>C. C. Zimmerman</u>			105 South Centre Street, Cumberland, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u>			ADDRESS <u>Cumberland, Maryland</u>		
24a. REC'D BY REGISTRAR <u>Aug. 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1957

RECEIVED

08081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>02</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u> d. STREET ADDRESS <u>1222 Wallace St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irene</u> <u>Matthews</u> First Middle Last		4. DATE OF DEATH <u>August 30</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1893</u> 84 yrs. <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, event if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> Hours <u>17</u> IF UNDER 24 HRS. Min. <u>17</u>
11. BIRTHPLACE (State or foreign country) <u>Williamsburg W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Kent</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Love</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas Matthews</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Fracture of right neck of femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.0</u> 19. WAS AUTOPSY PERFORMED? <u>NO</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4</u> p. m. <u>Aug. 25</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberland, Alleg. Md.</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 30, 1957</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		24a. REC'D BY REGISTRAR <u>W. Ross Cameron M.D.</u>	
ADDRESS <u>Cumb. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Acting Registrar</u>	

101 STATE
DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

SEP 4 1957

RECEIVED

08082

CERTIFICATE OF DEATH

08095

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS 222 Columbia Street.			
3. NAME OF DECEASED (Type or print) First Mildred Middle Virginia Last McDaniels				4. DATE OF DEATH Month August Day 7 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 30, 1915	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42 Days 7 Hours 19 Min. 57		IF UNDER 24 HRS. Months 42 Days 7 Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Young				14. MOTHER'S MAIDEN NAME Anna Graham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Patients chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Peritonitis, post-op. 216x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenomyosis uteri DUE TO (c) Hemorrhagic cysts of both ovaries ? months				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 d.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 29, 1957 , to Aug 7, 1957 , that I last saw the deceased alive on Aug 7, 1957 , and that death occurred at 4:40 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. J. Mirkin M.D.				ADDRESS (Street, city or town, state) 115 S. Centre St., Cumberland, Md.			
DATE SIGNED 8/7/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 9/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug 8, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

HUSBAND

DEATH OF INFANT OR CHILD UNDER FIVE YEARS OF AGE

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

WEIGHT AT BIRTH

LENGTH AT BIRTH

HEAD CIRCUMFERENCE AT BIRTH

SKULL CIRCUMFERENCE AT BIRTH

CHEST CIRCUMFERENCE AT BIRTH

ABDOMEN CIRCUMFERENCE AT BIRTH

ARM CIRCUMFERENCE AT BIRTH

LEG CIRCUMFERENCE AT BIRTH

FEET CIRCUMFERENCE AT BIRTH

HAIR COLOR

EYES COLOR

SKIN COLOR

TEETH

HEARING

VISION

SMELL

TASTE

VOICE

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATION

DIAPHRAGM

STOMACH

INTESTINES

BLADDER

RECTUM

GENITALS

PERINEUM

ANUS

URETHRA

VAGINA

CERVIX

UTERUS

OVARY

TUBES

PERITONEUM

DIAPHRAGM

WILL HOLD

DATE OF DEATH

TIME OF DEATH

WEIGHT AT DEATH

LENGTH AT DEATH

HEAD CIRCUMFERENCE AT DEATH

SKULL CIRCUMFERENCE AT DEATH

CHEST CIRCUMFERENCE AT DEATH

ABDOMEN CIRCUMFERENCE AT DEATH

ARM CIRCUMFERENCE AT DEATH

LEG CIRCUMFERENCE AT DEATH

FEET CIRCUMFERENCE AT DEATH

HAIR COLOR

EYES COLOR

SKIN COLOR

TEETH

HEARING

VISION

SMELL

TASTE

VOICE

TEMPERATURE

PULSE

BLOOD PRESSURE

RESPIRATION

DIAPHRAGM

STOMACH

INTESTINES

BLADDER

RECTUM

GENITALS

PERINEUM

ANUS

URETHRA

VAGINA

CERVIX

UTERUS

OVARY

TUBES

PERITONEUM

DIAPHRAGM

BUREAU V. 3

MAY 9 1957

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CONFIDENTIAL, MD.

DEPT. OF HEALTH

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DEPT. OF HEALTH

CONFIDENTIAL, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08096

Reg. Dist. No.

08083

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 47 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Garage) #1 Boone St.			d. STREET ADDRESS 11 Boone St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Evan Last Mc Donald			4. DATE OF DEATH Month Aug. Day 3 Year 19 57		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10-1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during longest of working life, even if retired) Retired Real Estate		10b. KIND OF BUSINESS OR INDUSTRY & Ins.		11. BIRTHPLACE (State or foreign country) Forks of Capon, W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George Mc Donald			14. MOTHER'S MAIDEN NAME Mollie Carter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-3106		17. INFORMANT Address (wife) Mrs. Wm. McDonald, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage due to a 22 DUE TO (b) caliber bullet wound through head. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) (Self inflicted)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 976x		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot himself in right temporal region-22 rifle			
20c. TIME OF INJURY Month, Day, Year Hour 12:40 a. m. Aug. 3 19 57 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Garage at home Cumberland Allegany Md.	
20f. (City or town) (County) (State) Cumberland Allegany Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H. V. Deming M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) H. V. Deming M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER Aug. 3-1957		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Hiett Cemetery	
22d. LOCATION (City, town, or county) (State) Forks of Cacapon, West Virginia.					
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.			24a. REC'D BY REGISTRAR Aug. 5, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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10 AUG 1954

RECEIVED

08119

CERTIFICATE OF DEATH

08097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN TB 6 wks.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital			
d. STREET ADDRESS 201 McCulloh St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last McKENZIE				4. DATE OF DEATH Month Aug. Day 29 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired rubber worker				10b. KIND OF BUSINESS OR INDUSTRY Kelly Spgf'd Tire.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lewis McKenzie				14. MOTHER'S MAIDEN NAME Mary McKenzie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-10-6820		17. INFORMANT Mrs. Mary McKenzie, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Fibrillation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardiovascular Disease DUE TO (c) 10 1/2 yrs -				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1957 , to Aug. 29, 1957 , that I last saw the deceased alive on Aug 29, 1957 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.			
DATE SIGNED 8-31-57				24b. REGISTRAR'S SIGNATURE Miss Nancy N. Rose			
PHYSICIAN'S NAME (Type) John B. Davis, M. D.				Broadway, Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 8-31-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		1912-01-15	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		1957-09-01		10:30 AM	
Occupation		Manner of Death		Physician's Signature		Physician's Title	
Teacher		Natural		J. Smith		M.D.	
Signature of Informant		Relationship to Deceased		Signature of Registrar		Date of Registration	
Jane Doe		Wife		A. Jones		1957-09-02	

BUREAU V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08098

CERTIFICATE OF DEATH

Reg. Dist. No. 4

08084

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 Greene St.		d. STREET ADDRESS 69 Greene St.	
3. NAME OF DECEASED (Type or print) Anna M. McNally		4. DATE OF DEATH Month Aug. Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1869
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Piedmont, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Mullen		14. MOTHER'S MAIDEN NAME Annie Laurie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Thos. Brooks		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/9 , 19 52 , to 8/29 , 19 57 , that I last saw the deceased alive on 8/28 , 19 57 , and that death occurred at 4:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland Md.	
PHYSICIAN'S NAME (Type) LEO H. LEY JR.		DATE SIGNED 9/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Sept. 2, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

BUREAU V. B.

SEP 4 1957

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DR. RANSOM

08085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 1/2 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 231 OAK STREET			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MERINELLI , Middle BABY Last GIRL				4. DATE OF DEATH Month AUGUST Day 24 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 23, 1957	
				9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND			
13. FATHER'S NAME LOUIE MERINELLI				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME ORSOLA CAVEZZA							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure of development of Vital Functions 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Craniorachisarcosis, Myelencephalocoele 4 1/2 hrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 28 Aug 1957 to 29 Aug 1957 that I last saw the deceased alive on 23 Aug 1957 and that death occurred at 12:30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 Greene St., Cumberland, Md DATE SIGNED 24 Aug							
ACTUAL SIGNATURE L. Ransom M.D.				PHYSICIAN'S NAME (Type) DR. L. RANSOM			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 8-24-57		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital	
				22d. LOCATION (City, town, or county) (State) Cumberland Md			
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital ADDRESS Cumberland, Md				24a. REC'D BY REGISTRAR Aug 24, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060251XV3

CERTIFICATE OF DEATH

NAME OF DECEASED BERNARD, HARRY KEN		SEX MALE		AGE 45		DATE OF BIRTH AUGUST 23, 1907		PLACE OF BIRTH BALTIMORE, MARYLAND	
RACE WHITE		OCCUPATION LABORER		MARITAL STATUS SINGLE		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
DECEASED AT 1012 EPHRAIM		PLACE OF DEATH BALTIMORE, MARYLAND		DATE OF DEATH SEPTEMBER 1, 1957		TIME OF DEATH 10:30 AM		CAUSE OF DEATH HEART DISEASE	
INTERVIEWED BY J. L. WILSON		DATE OF INTERVIEW SEPTEMBER 1, 1957		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. 2

AUG 27 1957

RECEIVED

1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08100

CERTIFICATE OF DEATH

08086

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>9 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>648 N. Mechanic St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Franklin</u> (Middle) <u>Martin</u> (Last) <u>Miller</u>				(Month) <u>Aug.</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3/26/07</u>	<u>50</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Caretaker</u>		<u>Ed. Stage Armory</u>		<u>Cumberland Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Clarence Miller (Deceased)</u>				<u>Amelia Reichart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>217-10-7875</u>		<u>Pts. chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
550.1 IMMEDIATE CAUSE (A) <u>Peritonitis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ruptured Gangrenous Appendix</u>						<u>13 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>13 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>15 Aug 57</u>		<u>Ruptured Gangrenous Appendix</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>15 Aug., 1957</u> , to <u>24 Aug., 1957</u> , that I last saw the deceased alive on <u>24 Aug., 1957</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Curtis Brunsford</u>				ADDRESS (Street, city, town, state) <u>M.D. 232 Baltimore Ave Cumberland Aug 27</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 28, 1957</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 29, 1957</u>		<u>W. Ross Cameron, M.D.</u>		<u>John J. Hafer,</u>		<u>Cumberland, Maryland</u>	
		<u>Acting Registrar</u>					

CERTIFICATE OF DEATH

Form 100-1-10

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING

NAME OF DECEASED: JOHN J. BROWN
AGE: 45 YEARS
SEX: MALE
DATE OF DEATH: 1957

PLACE OF DEATH: HOME
CAUSE OF DEATH: HEART DISEASE
MANNER OF DEATH: NATURAL

DATE OF BIRTH: 1912
PLACE OF BIRTH: MASSACHUSETTS
OCCUPATION: CLERK

DECEASED'S RESIDENCE: 123 MAIN ST., BOSTON, MASS.
DECEASED'S SIGNATURE: [Signature]
DECEASED'S ADDRESS: 123 MAIN ST., BOSTON, MASS.

DECEASED'S OCCUPATION: CLERK
DECEASED'S EMPLOYER: ABC COMPANY
DECEASED'S SOCIAL SECURITY NUMBER: 123-45-6789

DECEASED'S MARITAL STATUS: MARRIED
DECEASED'S SPOUSE'S NAME: MARY J. BROWN
DECEASED'S SPOUSE'S ADDRESS: 123 MAIN ST., BOSTON, MASS.

DECEASED'S EDUCATION: HIGH SCHOOL
DECEASED'S RELIGION: CATHOLIC
DECEASED'S RACE: WHITE

DECEASED'S DATE OF BIRTH: 1912
DECEASED'S PLACE OF BIRTH: MASSACHUSETTS
DECEASED'S OCCUPATION: CLERK

DECEASED'S EMPLOYER: ABC COMPANY
DECEASED'S SOCIAL SECURITY NUMBER: 123-45-6789
DECEASED'S MARITAL STATUS: MARRIED

DECEASED'S SPOUSE'S NAME: MARY J. BROWN
DECEASED'S SPOUSE'S ADDRESS: 123 MAIN ST., BOSTON, MASS.
DECEASED'S EDUCATION: HIGH SCHOOL

RECEIVED

BUREAU V. S.

AUG 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08101

Reg. Dist. No.

08087

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY Los Angeles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Los Angeles		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS Manhattan Beach.			
3. NAME OF DECEASED (Type or print) First Harley Middle Floyd Last Miller				4. DATE OF DEATH Month Aug. Day 2 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5-1888	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Tunnelton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allan Miller				14. MOTHER'S MAIDEN NAME Cora L. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT (brother) Willis Miller, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion (left) DUE TO Coronaryosteal narrowing also had Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Duodenal ulcer. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1. 1/2 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aug. 2-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				24a. REC'D BY REGISTRAR Aug. 5, 1957			
ADDRESS Cumberland, Md.				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

AUG 6 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08102

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN Yr 57 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing x 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 90 W. Main St.				d. STREET ADDRESS 90 W. Main St.			
3. NAME OF DECEASED (Type or print) First Middle Last James Love Moffatt				4. DATE OF DEATH Month Day Year Aug. 15 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1899		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Moffatt				14. MOTHER'S MAIDEN NAME Martha Sourbrine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-2719		17. INFORMANT Address Mrs. James L. Moffatt-Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 162X DUE TO Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Aoting			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/57		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR 8/17/57	
						24b. REGISTRAR'S SIGNATURE Janetle M. Boral	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1910		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 Main St.		Carpenter		Heart Disease		Natural		Aug 20, 1957		New York	
FAMILY PHYSICIAN		HOSPITAL		CORONER		MEDICAL EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	
Dr. J. J. Jones		St. Mary's		John Doe		James J. Jones		Aug 20, 1957		New York	
SIGNATURE OF MEDICAL EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF CORONER		DATE OF EXAMINATION		PLACE OF EXAMINATION	
James J. Jones		Aug 20, 1957		New York		John Doe		Aug 20, 1957		New York	

BUREAU V. S.

AUG 20 1957

RECEIVED

08088

CERTIFICATE OF DEATH

08103

Reg. Dist. No. 4

Within corporate limits

Page 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 52I Essex Place				d. STREET ADDRESS 52I Essex Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Mullan				4. DATE OF DEATH Month Aug. Day 12 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Mullan				14. MOTHER'S MAIDEN NAME Catherine Petri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Kathleen Mullan 52I Essex Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Atherosclerosis DUE TO 3 years (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 10, 1957 to August 12, 1957 that I last saw the deceased alive on August 10, 1957 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 8-13-57							
ACTUAL SIGNATURE J. T. Johnson Jr. M.D.							
PHYSICIAN'S NAME (Type) James T. Johnson Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-57		22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug 14, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.		Acting Registrar	

CERTIFICATE OF DEATH

Date of Birth

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. TIME OF DEATH [Faint text]</p>	
<p>7. PLACE OF DEATH [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. 2

AUG 15 1957

RECEIVED

Within corporate limits

08089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 66 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 534 Valley Street				d. STREET ADDRESS 534 Valley Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Daniel Middle Marcellus Last Mullan				4. DATE OF DEATH Month August Day 14 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30 1891	
9. AGE (In years lost birthday) yrs. 66		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp		11. BIRTHPLACE (State or foreign country) Cumberland Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Mullan				14. MOTHER'S MAIDEN NAME Anna Carlos			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 717-10-7068		17. INFORMANT Mrs. Clara Mullan, Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary emphysema DUE TO (c) 2 years				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 11 , 19 57 to Aug 14 , 19 57 , that I last saw the deceased alive on Aug 13 , 19 57 , and that death occurred at 7-30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Trevasick, Sr M.D. Cumberland, Md				DATE SIGNED 8/14/57			
PHYSICIAN'S NAME (Type) R. W. TREVASICK, SR Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 17 1957		22c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight ADDRESS Cumberland, Md				24a. REC'D BY REGISTRAR Aug 15, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08090 **CERTIFICATE OF DEATH**Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits; write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>2 days</u>		TOWN <u>Baltimore</u>		<u>0354.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>6 Larkspur Lane</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby</u> (First) <u>Boy</u> (Middle) <u>Girl</u> (Last) <u>Owens Twin #2</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>21</u> (Year) <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>8/22-57</u>	9. AGE last birthday yrs. <u>21</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Owens</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wharton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Paul Owens, Baltimore, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
761.0 IMMEDIATE CAUSE (A) <u>Fatal Anemia and Malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Due to Malnutrition Placenta</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>in Twin Pregnancy</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE <u>Harvey H. Zeigler</u> ADDRESS (Street, city, town, state) <u>Hyndman, Pa.</u> DATE SIGNED <u>Aug. 24, 1957</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-25-57</u>		NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>	
24. REC'D BY REGISTRAR <u>Aug. 24, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>		ADDRESS <u>Hyndman, Pa.</u>	

INSTRUCTIONS

1 **WITHIN CORPORATE LIMITS**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

22622222XVV

68105

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. OCCUPATION
8. MARITAL STATUS
9. COLOR
10. RELIGION
11. EDUCATION
12. SERVICE
13. CAUSE OF DEATH
14. MANNER OF DEATH
15. PERIOD OF ILLNESS
16. PREVIOUS ILLNESS
17. PREVIOUS SURGERY
18. PREVIOUS TRAUMA
19. PREVIOUS DRUGS
20. PREVIOUS ALCOHOL
21. PREVIOUS TOBACCO
22. PREVIOUS OTHER
23. PREVIOUS OTHER
24. PREVIOUS OTHER
25. PREVIOUS OTHER
26. PREVIOUS OTHER
27. PREVIOUS OTHER
28. PREVIOUS OTHER
29. PREVIOUS OTHER
30. PREVIOUS OTHER

31. SIGNATURE OF DECEASED
32. SIGNATURE OF WITNESS
33. SIGNATURE OF PHYSICIAN
34. SIGNATURE OF CLERK
35. SIGNATURE OF OTHER
36. SIGNATURE OF OTHER
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NOT RECORDED

BUREAU V. 1

NOV 27 1957

RECEIVED

08120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 W. Mechanic St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DANIEL First E. Middle PRICE Last				4. DATE OF DEATH Aug. Month 17, Day 19 Year 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Green Chevrolet Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George J. Price				14. MOTHER'S MAIDEN NAME Elizabeth Edwards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-07-5092			
17. INFORMANT Mrs. Emma Price,				Address Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) XXXXXX				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. XXXX 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) XXXX	
20f. (City or town) XXXXXX				(County) (State)			
21. I certify that I attended the deceased from March 4 , 19 57 , to August 17 , 19 57 , that I last saw the deceased alive on August 17 , 19 57 , and that death occurred at 8:55A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin M. Rothstein M.D.				ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.			
DATE SIGNED 8/18/57							
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 8-19-57	
24b. REGISTRAR'S SIGNATURE Nancy N. R.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>	
<p>6. OCCUPATION [Faint text]</p>		<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>		<p>9. TIME OF DEATH [Faint text]</p>		<p>10. PLACE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>		<p>13. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>14. SIGNATURE OF CORONER [Faint text]</p>		<p>15. SIGNATURE OF JURY [Faint text]</p>	

BUREAU V. S.

JUN 23 1957

RECEIVED

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08107

08091

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		LENGTH OF STAY (In this place) <u>33 Hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>#6 VIRGINIA AVE.</u>					
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH H. PUGH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 13 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>6/15, - 1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAOLIN PUGH</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA NIXON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>ADDRESS AS ABOVE.</u> <u>NIECE by MARRIAGE, AUDRA PUGH</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-13</u>, 19<u>57</u>, to <u>8-14</u>, 19<u>57</u>, that I last saw the deceased alive on <u>8-14</u>, 19<u>57</u>, and that death occurred at <u>8-15</u>, M., from the causes and on the date stated above. SIGNATURE <u>Chas. L. George</u> M.D. <u>62 Greene St. Cumberland, Md.</u> DATE SIGNED <u>8-15-57</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-16-1957</u>		NAME OF CEMETERY OR CREMATORY <u>Queens Point Cem.</u>		LOCATION (City, town, or county) (State) <u>Keyser, W. Va.</u>	
24. REC'D BY REGISTRAR <u>Aug. 16, 1957</u>		REGISTRAR'S SIGNATURE <u>W. P. Cameron, M.D.</u> <u>Acting Registrar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>			

CERTIFICATE OF DEATH

1909

1. DEATH OCCURRED BETWEEN

DATE OF DEATH

NAME OF DECEASED

MR. MEDICAL CERTIFICATION

DEATH OF THE DECEASED, I HAVE EXAMINED
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BUREAU V. S.

AUG 10 1909

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NOTATION

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 TO BE SUBMITTED BY THE DEATH
 TO BE SUBMITTED BY THE DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

08092

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08108

DR. R.J. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA. 85X-3			
d. STREET ADDRESS 2 JOHN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEO Middle Martin Last RHODES				4. DATE OF DEATH Month AUGUST Day 9 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 2, 1905	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator				10b. KIND OF BUSINESS OR INDUSTRY CELANESE Corp.		11. BIRTHPLACE (State or foreign country) MARYLAND Swanton,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE M. RHODES				14. MOTHER'S MAIDEN NAME BRIDGETT HANDLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 232-10-9193		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) 20 yrs							INTERVAL BETWEEN ONSET AND DEATH 12 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/6/57 , 19___, to 8/9/57 , 19___, that I last saw the deceased alive on 8/9/57 , 19___, and that death occurred at 11:25 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Cumberland				DATE SIGNED 8/9/57			
ACTUAL SIGNATURE R.J. Williams M.D.							
PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug. 12, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

NAME OF DECEASED WILLIAMS, ROBERT J.		AGE 30		SEX MALE		RACE WHITE		DATE OF DEATH JULY 1, 1957		PLACE OF DEATH HOSPITAL	
RESIDENCE 1234 E. STREET, BALTIMORE, MD.		DATE OF BIRTH JULY 1, 1927		PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
FATHER'S NAME WILLIAMS, ROBERT J.		MOTHER'S NAME WILLIAMS, MARY		FATHER'S OCCUPATION LABORER		MOTHER'S OCCUPATION HOUSEWIFE		FATHER'S RESIDENCE 1234 E. STREET, BALTIMORE, MD.		MOTHER'S RESIDENCE 1234 E. STREET, BALTIMORE, MD.	
FATHER'S SIGNATURE ROBERT J. WILLIAMS		MOTHER'S SIGNATURE MARY WILLIAMS		FATHER'S ADDRESS 1234 E. STREET, BALTIMORE, MD.		MOTHER'S ADDRESS 1234 E. STREET, BALTIMORE, MD.		FATHER'S PHONE 123-4567		MOTHER'S PHONE 123-4567	
FATHER'S SIGNATURE ROBERT J. WILLIAMS		MOTHER'S SIGNATURE MARY WILLIAMS		FATHER'S ADDRESS 1234 E. STREET, BALTIMORE, MD.		MOTHER'S ADDRESS 1234 E. STREET, BALTIMORE, MD.		FATHER'S PHONE 123-4567		MOTHER'S PHONE 123-4567	

RECEIVED
AUG 18 1957
BUREAU V. S.

08093

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 609 PIEDMONT AVE.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last ROEDER				4. DATE OF DEATH Month AUGUST Day 7 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 1 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHRISTIAN ROEDER				14. MOTHER'S MAIDEN NAME CATHERINE SCHULTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Erma Roeder, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Cardiac decompensation Diabetic mellitus							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1955 , to Aug 7, 1957 , that I last saw the deceased alive on Aug 7, 1957 , and that death occurred at 10:14 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1200 Mount Cumberland, Md DATE SIGNED 8/8/57							
ACTUAL SIGNATURE George M. Simons M.D.				PHYSICIAN'S NAME (Type) GEORGE M. SIMONS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park Cumberland, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.				24a. REC'D BY REGISTRAR Aug 8, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED CHARLES		AGE 30		SEX MALE		RACE WHITE		DATE OF DEATH JULY 1 1883		PLACE OF DEATH CHICAGO, ILL.	
NATURAL CAUSE OF DEATH TUBERCULOSIS		MANNER OF DEATH NATURAL		LOCALITY OF DEATH CHICAGO, ILL.		CITY OF DEATH CHICAGO, ILL.		COUNTY OF DEATH COOK, ILL.		STATE OF DEATH ILLINOIS	
NAME OF PHYSICIAN DR. J. H. HARRIS		NAME OF FUNERAL HOME J. H. HARRIS		NAME OF BURIAL PLACE MOUNT CARMEL		NAME OF CEMETERY MOUNT CARMEL		NAME OF MINISTER J. H. HARRIS		NAME OF CHURCH MOUNT CARMEL	
NAME OF NEXT OF KIN J. H. HARRIS		NAME OF WITNESS J. H. HARRIS		NAME OF JURY J. H. HARRIS		NAME OF JURY J. H. HARRIS		NAME OF JURY J. H. HARRIS		NAME OF JURY J. H. HARRIS	

RECEIVED

BUREAU V. 2

AUG 3 1957

WILLIAM H. HARRIS, CHICAGO, ILL.

AUG. 10, 1957

ALL DEATHS MUST BE REPORTED TO THE HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. Dist. No.

C8094

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>104 Grand Ave.</u>		d. STREET ADDRESS <u>104 Grand Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Slizer Rudiger</u>		4. DATE OF DEATH Month Day Year <u>August 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 31, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sun Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abel D Randall</u>		14. MOTHER'S MAIDEN NAME <u>Honora Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year if unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Fredrick C Rudiger</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>572.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diverticulitis of Sigmoid</u> DUE TO (c) <u>4 mon.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10, 1957</u> to <u>Aug 23, 1957</u> that I last saw the deceased alive on <u>Aug. 22, 1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>8/24/57</u>	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 26 1957</u>	<u>Rose Hill Cem.</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumberland Md</u>	24a. REC'D BY REGISTRAR <u>Aug 26, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 18

Page One

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		Male		35		1922		Missouri		Minister	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
April 4, 1968		Baltimore, Maryland		Suicide		Natural		[Signature]		[Signature]	
13. SIGNATURE OF NEXT OF KIN		14. SIGNATURE OF MINISTER		15. SIGNATURE OF CHURCH		16. SIGNATURE OF BURIAL PLACE		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

AUG 27 1957

RECEIVED

08095 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES NELSON RUSSLER				4. DATE OF DEATH Month Day Year AUGUST 13 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor				10b. KIND OF BUSINESS OR INDUSTRY Music Store		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA							
13. FATHER'S NAME RUSSLER, NELSON				14. MOTHER'S MAIDEN NAME HUTZLER, LENORA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Site Colon DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/11/57 , 19 57 , to 8/12/57 , 19 57 , that I lost saw the deceased alive on 8/13/57 , 19 57 , and that death occurred at 3:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 8/14/57							
ACTUAL SIGNATURE DR. R. J. WILLIAMS M.D. XXXXXX							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-16-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Aug. 16, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

CERTIFICATE OF DEATH

File No. 100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1912		MASSACHUSETTS	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
100 Main St., Boston		Teacher		Heart Disease		Natural		June 10, 1957		Boston, Mass.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES J. JONES		MARY J. JONES		Teacher		Homemaker		Massachusetts		Massachusetts	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
1910		1915		Massachusetts		Massachusetts		Heart Disease		Heart Disease	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Natural		Natural		1950		1955		Massachusetts		Massachusetts	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
Heart Disease		Heart Disease		Natural		Natural		1950		1955	

BUREAU V. 3

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
08096					CERTIFICATE OF DEATH				
					Reg. Dist. No. 08143				
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 22 MINUTES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL * WARWICK & MEMORIAL AVES.					d. STREET ADDRESS 224 GLENN STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY SAMARAS					4. DATE OF DEATH Month Day Year AUGUST 3, 19 57.				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 3, 1957.		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THEOBORE J. SAMARAS					14. MOTHER'S MAIDEN NAME LEOTTA V. BURKHART				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL * CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Neonatorum 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration Meconium DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 Greene St., Cumberland, Md. DATE SIGNED MD 57									
ACTUAL SIGNATURE Leland B. Ransom M.D.					PHYSICIAN'S NAME (Type) DR. LEIAND B. RANSOM				
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Maryland.					24a. REC'D BY REGISTRAR Aug 6, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar		

2060281XV6

Within corporate limits

FOR STATE
HEALTH DEPT.

08097

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>		d. STREET ADDRESS <u>R.F.D. #3 Bedford Valley</u>	
3. NAME OF DECEASED (Type or print) <u>James Alexander Selby</u>		4. DATE OF DEATH <u>Aug 30 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>29</u> Hours <u>15</u> Min. <u>3</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Weaver</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp</u>	
13. BIRTHPLACE (State or foreign country) <u>Washington Co. Pa.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>James H. Selby</u>		16. MOTHER'S MAIDEN NAME <u>Ida H. Hughes</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>Elmer E. Selby Carnegie Pa</u>	
19. INFORMATION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to the immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right neck of femur</u> 902.0 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Patient fell from porch at home</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>July 1 1957</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Cumberland</u>		20g. (County) <u>Alleg.</u>	
20h. (State) <u>Maryland</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Aug. 30, 1957</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> acting			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 2 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Choyville Penna</u>		22d. LOCATION (City, town, or county) (State) <u>Choyville Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 31, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Ross Cammox, M.D.</u>		24c. <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 4 1957

BUREAU V. A.

STATE
DEPT

STATE DEPT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08098 CERTIFICATE OF DEATH

08115

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> Maryland b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Washington</u> Last <u>Shank</u>				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 75</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>30</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Train Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Renova, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Jacob Shank</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Irvin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>705-10-6049</u>			
16. SOCIAL SECURITY NO. <u>705-10-6049</u>				17. INFORMANT <u>Daughter Mrs. McNamee</u> Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8/23</u> , 19 <u>57</u> , to <u>8/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/29</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/30/57</u>							
ACTUAL SIGNATURE <u>Leo L. Lev, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Leo Lev, M.D.</u> <u>N. Center St., Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-1-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug. 31, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARRIED		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

SEP 7 1957

RECEIVED

08093 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>02</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>529 Cumberland Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROWLAND J. SHEPHERD</u>				4. DATE OF DEATH <u>August 10, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		11. BIRTHPLACE (State or foreign country) <u>Stanley, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Shepherd</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Rebecca Barrington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>322-01-8248</u>		17. INFORMANT <u>Mrs. R. J. Shepherd</u> <u>529 Cumberland Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Dis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Op. of V. erined Fracture 2-19-53</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>1-27-53</u> to <u>8-10-57</u> , that I last saw the deceased alive on <u>7-6-57</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>W. F. Williams</u> M.D. <u>Cumberland Md</u> DATE SIGNED <u>8-2-57</u> PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24. REC'D BY REGISTRAR <u>9-12-1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

08121

Item 5 Film 220 0-11-57 et

CERTIFICATE OF DEATH

08117

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
c. LENGTH OF STAY in 1b life				d. STREET ADDRESS 293 E. Main St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 293 E. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle M. Last SLEEMAN				4. DATE OF DEATH Month Aug. Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-9-1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired contractor				10b. KIND OF BUSINESS OR INDUSTRY Lumber business		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Sleeman				14. MOTHER'S MAIDEN NAME Margaret McFarland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. (215-10-4391)		17. INFORMANT Mrs. Edith Sleeman, Frostburg, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial insufficiency DUE TO 2 years (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19____, to Aug 20 , 19 57 , that I last saw the deceased alive on Aug 19 , 19 57 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Frostburg, Md.				DATE SIGNED Aug 21 1957			
ACTUAL SIGNATURE WOMC Lane M.D.							
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-1957		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 8-23-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Re			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08100 CERTIFICATE OF DEATH

08118

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 50yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 Springdale St.		d. STREET ADDRESS 109 Jackson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle H. Last Snyder		4. DATE OF DEATH Month Aug. Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Snyder		14. MOTHER'S MAIDEN NAME Sarah Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-4584	
17. INFORMANT Mary Snyder		Address 109 Jackson St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic myocarditis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1, 1957 to Aug. 13, 1957 ; that I last saw the deceased alive on Aug. 13, 1957 and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED Aug. 15, 1957			
ACTUAL SIGNATURE Clay E. Durrett M.D.			
PHYSICIAN'S NAME (Type) Clay E. Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-17-57	22c. NAME OF CEMETERY OR CREMATORY Hillcre st Burial Park Cumberland, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24. REC'D BY REGISTRAR Aug. 16, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

1. PLACE OF BIRTH		2. SEX	
3. RACE		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH	
9. DISEASE OR INJURY		10. MANNER OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF OFFICIAL	
19. SIGNATURE OF OFFICIAL		20. SIGNATURE OF OFFICIAL	
21. SIGNATURE OF OFFICIAL		22. SIGNATURE OF OFFICIAL	
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97. SIGNATURE OF OFFICIAL		98. SIGNATURE OF OFFICIAL	
99. SIGNATURE OF OFFICIAL		100. SIGNATURE OF OFFICIAL	

RECEIVED
AUG 19 1957
BUREAU V. S.

08122

CERTIFICATE OF DEATH

08419

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 22			
d. STREET ADDRESS 19 E. Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Cambell Snyder				4. DATE OF DEATH Month Day Year 8 17 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1892	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. Zimmerly				14. MOTHER'S MAIDEN NAME Anne E. Downie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Raymond Shoemaker		18. ADDRESS 19 East Main (Dght) Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix & uterus 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 11 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JUNE 2, 1957 , to AUG. 17, 1957 , that I last saw the deceased alive on AUG. 17, 1957 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 8-20-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg, Md.		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Berlin H. Montecant ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.							
24a. REC'D BY REGISTRAR DATE 8-20-57				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Hise			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	

BUREAU V. 1

SEP 3 1957

RECEIVED

08101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08120
4

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Grahamtown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>			d. STREET ADDRESS <u>69 Armstrong St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Herbert</u> Last <u>Sterry</u>			4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Herbert Sterry</u>		
14. MOTHER'S MAIDEN NAME <u>Florence Vincent</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>Irvin Sterry, 77 Ormand St. Frostburg, Md.</u>			17. INFORMANT <u>Irvin Sterry, 77 Ormand St. Frostburg, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Peptic Ulcer</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Days</u> <u>2-3 Days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Frostburg</u>	(County) <u>Md.</u>	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug. 29, 1957</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-I-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	22d. LOCATION (City, town, or county) <u>Frostburg</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict H. Montesant</u>		ADDRESS <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Aug 31, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>

FOR STATE
RECEIPT

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2-1-1957

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SEX: [illegible]

AGE: [illegible]

CAUSE OF DEATH: [illegible]

2-1-1957

2-1-1957

2-1-1957

2-1-1957

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2-1-1957

BUREAU V. S.

SEP 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08129 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08121
Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Samuel First Stevenson Middle Stevenson Last		4. DATE OF DEATH Month Aug. Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mine	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Stevenson		14. MOTHER'S MAIDEN NAME Margaret A. Olise Margaret A. Olise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 00	
17. INFORMANT Mrs. Howard Braitwaite-Beryll, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/57	
22c. NAME OF CEMETERY OR CREMATORY Bloomington		22d. LOCATION (City, town, or county) (State) Bloomington, Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR 8-15-57		DATE 8-15-57	
24b. REGISTRAR'S SIGNATURE John C. Kelly			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		1957		Home	
Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Physician		Signature of Coroner	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Residence		Date of Birth		Date of Death		Time of Death		Time of Examination		Time of Burial	
123 Main St.		1/1/1912		8/19/1957		10:00 AM		11:00 AM		12:00 PM	
City		County		State		Country		Burial Place		Burial Date	
Baltimore		Baltimore		Maryland		USA		Catholic		8/20/1957	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
St. Mary's		8/20/1957		12:00 PM		St. Mary's		8/20/1957		12:00 PM	

RECEIVED
 AUG 19 1957
 BUREAU V. S.

08102

CERTIFICATE OF DEATH

08122

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, rural x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE 4 Oldtown Road			
3. NAME OF DECEASED (Type or print) First ROSE Middle Combs Last SWEIGERT				4. DATE OF DEATH Month AUGUST Day 2 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 28 1913	
9. AGE (In years last birthday) yrs. 43		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Clean Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Ridgely	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Lemuel Combs				14. MOTHER'S MAIDEN NAME ALICE ORNDORFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Pulmonary 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral (metastatic) lungs DUE TO (c) 172 INTERVAL BETWEEN ONSET AND DEATH 48 hrs				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1/57 , 19, to 8/2/57 , 19, that I last saw the deceased alive on 8/1/57 , 19, and that death occurred at 7:35 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) Cumberland DATE SIGNED 8/3/57							
ACTUAL SIGNATURE DR. RICHARD J. WILLIAMS M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-57		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Aug. 6, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

08103 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Arch Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.			
f. STREET ADDRESS 1 111 Arch Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Luther Last Trail				4. DATE OF DEATH Month Aug. Day 16 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1875	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 15 Hours 7 Min.		11. BIRTHPLACE (State or foreign country) Piney Grove, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad			
13. FATHER'S NAME Hughy Trail				14. MOTHER'S MAIDEN NAME Rachel Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mrs. Frances Haines, Springfield, W. Va.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8/5/57 1945-							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/5 , 19 57 , to 8/16 , 19 57 , that I last saw the deceased alive on 8/16 , 19 57 , and that death occurred at 10 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 126 7th St. Cumberland, Md. DATE SIGNED 8/19/57 ACTUAL SIGNATURE H. W. Eliason M.D. PHYSICIAN'S NAME (Type) H. W. ELIASON - 126 7th St. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24. REC'D BY REGISTRAR Aug. 20, 1957			
25. ADDRESS James F. Scarpelli, Cumberland, Md.				26. REGISTRAR'S SIGNATURE A. Ross Cameron M.D. Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-1

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 65		4. RACE WHITE		5. DATE OF DEATH Aug 21 1957		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH Home		8. COUNTY BALTIMORE		9. CITY BALTIMORE		10. STATE MARYLAND	
11. MARITAL STATUS Married		12. OCCUPATION Retired		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. MEDICAL HISTORY None		16. PREVIOUS ILLNESS None		17. SURVIVAL Yes		18. SIGNATURE OF DECEASED None		19. SIGNATURE OF WITNESSES None		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	
21. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		22. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		25. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		28. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		29. SIGNATURE OF DECEASED'S NEAREST RELATIVE None		30. SIGNATURE OF DECEASED'S NEAREST RELATIVE None	

BUREAU V. 3

AUG 21 1957

RECEIVED

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08104

CERTIFICATE OF DEATH

08125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>704 BAKER STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>BERDIE</u> Middle <u>Violet</u> Last <u>TWIGG</u>				4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-06</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>William Cowgill</u>			
14. MOTHER'S MAIDEN NAME <u>Electia Rainer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Patients chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>5 - 9</u> , 19 <u>56</u> , to <u>8 - 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 - 6</u> , 19 <u>57</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Peggy W. Ballin</u> M.D. <u>8 - 6 - 57</u> PHYSICIAN'S NAME (Type) <u>R.W. Ballin, M.D.</u> <u>62 Green St., Cumberland, Md.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8/8/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Olivers Grove Meth. Cem</u> 22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u> 24a. REC'D BY REGISTRAR <u>Aug 9, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

Aug 12 1957

RECEIVED

08105 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 5 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - MEMORIAL AVE.			d. STREET ADDRESS 83X-3		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last VANCE			4. DATE OF DEATH Month AUGUST Day 7 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 23, 1897		9. AGE (In years last birthday) yrs. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House painting	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME LUTHER A. VANCE			14. MOTHER'S MAIDEN NAME ROSABELLE THORN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 228 26 2277	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 8/7 , 19 57 , to 8/7 , 19 57 , that I last saw the deceased alive on 8/7 , 19 57 , and that death occurred at 4:08 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 W. Main St., Cumberland, Md. DATE SIGNED 8/8/57					
ACTUAL SIGNATURE George M. Simons M.D.					
PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland Md.			24. REC'D BY REGISTRAR Aug 8, 1957		
			24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 2

AUG 9 1957

RECEIVED

AUG. 10, 1957 Davis Memorial Cem. Campbell

10101 N. 1st St., Baltimore, Md.

NO. 10101 N. 1st St.

10101 N. 1st St., Baltimore, Md.

BUREAU V. 3

BUREAU V. 3

08107

CERTIFICATE OF DEATH

08128

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EVERETT 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 117 SOUTH ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle WEIMER Last WEIMER				4. DATE OF DEATH Month AUGUST Day 15 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 69	IF UNDER 24 HRS. Days 69 Hours 69 Min. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKING		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING INDUSTRY		11. BIRTHPLACE (State or foreign country) BEDFORD CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. WEIMER				14. MOTHER'S MAIDEN NAME BARBARA FLETCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL		17. INFORMANT Address MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Benign hypertrophy prostate 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) ? (c) ?							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary sclerosis Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8-7- , 19 57 , to 8-15- , 19 57 , that I last saw the deceased alive on 8-15- , 19 57 , and that death occurred at 10:20 AM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Howard Tolson, M.D., Cumberland, Md.				DATE SIGNED 8-15-57			
ACTUAL SIGNATURE Howard Tolson				PHYSICIAN'S NAME (Type) DR. HOWARD TOLSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery		22d. LOCATION (City, town, or county) (State) Everett, Pennsylvania.	
23. FUNERAL DIRECTOR'S SIGNATURE Lynford J. Canner				ADDRESS Everett Pa.		24a. REC'D BY REGISTRAR W. Ross Cameron, M.D. DATE Aug. 17, 1957 24b. REGISTRAR'S SIGNATURE Acting Registrar	

BUREAU V. 8

1957 20 JUN

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08108

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>01 Cumberland</u>		
c. LENGTH OF STAY IN 1b <u>45 minutes</u>			d. STREET ADDRESS <u>462 Goethe Street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUST LEONARD WELLS</u>			4. DATE OF DEATH Month Day Year <u>August 12 19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1915</u>		9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Wkr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corporation</u>	11. BIRTHPLACE (State or foreign country) <u>Monticello, Decatur, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Cecil Leonard Wells</u>			14. MOTHER'S MAIDEN NAME <u>Hilda Blaul</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11 2 214-07-1524</u>	17. INFORMANT <u>Mrs. Ann C. Wells</u> <u>462 Goethe Street Cumberland, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> DUE TO (b) <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>(45 Minutes)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3/45 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>self inflicted</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9:15 PM</u> p. m. <u>8/12/57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Cumberland, Alleg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		8/12/57 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cath. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			24a. REC'D BY REGISTRAR <u>Aug. 15, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D. Acting Registrar</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
SIGNATURE OF EXAMINER		DATE		TIME		LOCATION		HOSPITAL		CITY	
STATE		COUNTY		TOWNSHIP		PARISH		CITY		ZIP CODE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED		DATE		TIME	

BUREAU Y. 3

AUG 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08130

Reg. Dist. No.

08109

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M d. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 71 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 317 Bedford St.		d. STREET ADDRESS 317 Bedford St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Helen C. L. Wildmann		4. DATE OF DEATH Month Aug. Day 6 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13-1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady		10b. KIND OF BUSINESS OR INDUSTRY Shoe Store	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Wildmann		14. MOTHER'S MAIDEN NAME Gertrude Muth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-6236A	
17. INFORMANT (Mrs. Robt. Ehrbar, Cumberland, Md.)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Aug. 6-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland		24a. REC'D BY REGISTRAR Aug. 8, 1957	
ADDRESS Stein		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. OCCUPATION [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. DATE OF BIRTH [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. SIGNATURE OF EXAMINER [REDACTED]	
11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JUDGE [REDACTED]	
15. SIGNATURE OF CLERK [REDACTED]		16. SIGNATURE OF RECORDS [REDACTED]	
17. SIGNATURE OF [REDACTED]		18. SIGNATURE OF [REDACTED]	
19. SIGNATURE OF [REDACTED]		20. SIGNATURE OF [REDACTED]	
21. SIGNATURE OF [REDACTED]		22. SIGNATURE OF [REDACTED]	
23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]	
25. SIGNATURE OF [REDACTED]		26. SIGNATURE OF [REDACTED]	
27. SIGNATURE OF [REDACTED]		28. SIGNATURE OF [REDACTED]	
29. SIGNATURE OF [REDACTED]		30. SIGNATURE OF [REDACTED]	
31. SIGNATURE OF [REDACTED]		32. SIGNATURE OF [REDACTED]	
33. SIGNATURE OF [REDACTED]		34. SIGNATURE OF [REDACTED]	
35. SIGNATURE OF [REDACTED]		36. SIGNATURE OF [REDACTED]	
37. SIGNATURE OF [REDACTED]		38. SIGNATURE OF [REDACTED]	
39. SIGNATURE OF [REDACTED]		40. SIGNATURE OF [REDACTED]	
41. SIGNATURE OF [REDACTED]		42. SIGNATURE OF [REDACTED]	
43. SIGNATURE OF [REDACTED]		44. SIGNATURE OF [REDACTED]	
45. SIGNATURE OF [REDACTED]		46. SIGNATURE OF [REDACTED]	
47. SIGNATURE OF [REDACTED]		48. SIGNATURE OF [REDACTED]	
49. SIGNATURE OF [REDACTED]		50. SIGNATURE OF [REDACTED]	
51. SIGNATURE OF [REDACTED]		52. SIGNATURE OF [REDACTED]	
53. SIGNATURE OF [REDACTED]		54. SIGNATURE OF [REDACTED]	
55. SIGNATURE OF [REDACTED]		56. SIGNATURE OF [REDACTED]	
57. SIGNATURE OF [REDACTED]		58. SIGNATURE OF [REDACTED]	
59. SIGNATURE OF [REDACTED]		60. SIGNATURE OF [REDACTED]	
61. SIGNATURE OF [REDACTED]		62. SIGNATURE OF [REDACTED]	
63. SIGNATURE OF [REDACTED]		64. SIGNATURE OF [REDACTED]	
65. SIGNATURE OF [REDACTED]		66. SIGNATURE OF [REDACTED]	
67. SIGNATURE OF [REDACTED]		68. SIGNATURE OF [REDACTED]	
69. SIGNATURE OF [REDACTED]		70. SIGNATURE OF [REDACTED]	
71. SIGNATURE OF [REDACTED]		72. SIGNATURE OF [REDACTED]	
73. SIGNATURE OF [REDACTED]		74. SIGNATURE OF [REDACTED]	
75. SIGNATURE OF [REDACTED]		76. SIGNATURE OF [REDACTED]	
77. SIGNATURE OF [REDACTED]		78. SIGNATURE OF [REDACTED]	
79. SIGNATURE OF [REDACTED]		80. SIGNATURE OF [REDACTED]	
81. SIGNATURE OF [REDACTED]		82. SIGNATURE OF [REDACTED]	
83. SIGNATURE OF [REDACTED]		84. SIGNATURE OF [REDACTED]	
85. SIGNATURE OF [REDACTED]		86. SIGNATURE OF [REDACTED]	
87. SIGNATURE OF [REDACTED]		88. SIGNATURE OF [REDACTED]	
89. SIGNATURE OF [REDACTED]		90. SIGNATURE OF [REDACTED]	
91. SIGNATURE OF [REDACTED]		92. SIGNATURE OF [REDACTED]	
93. SIGNATURE OF [REDACTED]		94. SIGNATURE OF [REDACTED]	
95. SIGNATURE OF [REDACTED]		96. SIGNATURE OF [REDACTED]	
97. SIGNATURE OF [REDACTED]		98. SIGNATURE OF [REDACTED]	
99. SIGNATURE OF [REDACTED]		100. SIGNATURE OF [REDACTED]	

BUREAU V. 2

AUG 9 1957

RECEIVED

08110

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write CUMBERLAND) RURAL and give nearest town)				c. LENGTH OF STAY IN 1b 29 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MERTIN Middle A. Last WISE				4. DATE OF DEATH Month AUGUST Day 12 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 30, 1889		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER		10b. KIND OF BUSINESS OR INDUSTRY QUEEN CITY DAIRY		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WISE				14. MOTHER'S MAIDEN NAME MINNIE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Peace Time 214-05-4573		17. INFORMANT MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident (thrombosis) 260 X DUE TO with L. hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic heart disease DUE TO 3 years (c) Diabetes mellitus DUE TO 20 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1942 to 11 Aug. 1957 that I last saw the deceased alive on 11 Aug. 1957 , and that death occurred at 11:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12 Aug. 57							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				PHYSICIAN'S NAME (Type) DR. W. VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Aug 14, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

1 Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 15 1957

BUREAU V. 5